



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH AUSTIN SURGERY CENTER
12201 RENFERT WAY SUITE 120
AUSTIN TX 78758

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-2881-01

MFDR Date Received

APRIL 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Overpaid Procedure". "No Payment Issued."

Amount in Dispute: \$2182.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale as follows: Denied 29823 RT as the code billed does not meet the level/description of the procedure performed/documented. Debridement of biceps tendon and labrum are included in repair of 29807 and 23430."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2010	ASC Services for Code 23430-RT	-\$1.93	-\$1.96
October 27, 2010	ASC Services for Code 29807-RT	-\$4.05	-\$0.06
October 27, 2010	ASC Services for Code 29823-RT	\$2188.81	\$2,188.77
TOTAL		\$2182.83	\$2,186.75

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 8, 2010

- 42- Charges exceed our fee schedule or maximum allowable amount.
- 59- Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- Z346-Right side.
- U403-This multiple procedure was reduced 50 percent according to fee schedule or usual and customary guidelines.
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.

Explanation of benefits dated February 21, 2011

- 42- Charges exceed our fee schedule or maximum allowable amount.
- 59- Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- Z346-Right side.
- U403-This multiple procedure was reduced 50 percent according to fee schedule or usual and customary guidelines.
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.

Issues

1. Did the requestor support position that an overpayment of \$1.93 was made for ASC services for code 23430-RT
2. Did the requestor support position that an overpayment of \$4.05 was made for ASC services for code 29807-RT? Is the requestor entitled to reimbursement?
3. Does the documentation support billed service for ASC services for code 29823-RT? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

CPT code 23430 is defined as "Tenodesis of long tendon of biceps."

28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for CPT code 23430 is:

The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures. The ASC fully implemented relative payment weight for CY 2010 = 43.4951.

This number is multiplied by the 2010 Medicare ASC conversion factor of 43.4951 X \$41.873 = \$1821.27.

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$910.63 (\$1821.27/2).

This number X City Conversion Factor/CMS Wage Index for Austin, Texas is \$910.63 X 0.9518 = \$866.73.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement \$910.63 + \$866.73 = \$1,777.36.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment \$1,777.36 X 235% = \$4,176.79.

CPT code 23430 is subject to multiple procedure discounting; therefore, \$4,176.79 X 50% = \$2,088.39.

The MAR for CPT code 23430 is \$2,088.39. The insurance carrier paid \$2,090.35. As a result, the amount of

overpayment is \$1.96.

2. CPT code 29807 is defined as "Arthroscopy, shoulder, surgical; repair of SLAP lesion."

28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for CPT code 29807 is:

The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures. The ASC fully implemented relative payment weight for CY 2010 = 45.5859.

This number is multiplied by the 2010 Medicare ASC conversion factor of 45.5859 X \$41.873 = \$1,908.81.

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$954.40 (\$1,908.81/2).

This number X City Conversion Factor/CMS Wage Index for Austin, Texas is \$954.40 X 0.9518 = \$908.39.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement \$954.40 + \$908.39 = \$1,862.79.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment \$1,862.79 X 235% = \$4,377.55.

The MAR for CPT code 29807 is \$4,377.55. The insurance carrier paid \$4377.61. As a result, the amount of overpayment is \$0.06.

3. CPT code 29823 is defined as "Arthroscopy, shoulder, surgical; debridement, extensive."

According to the explanation of benefits the respondent denied reimbursement for CPT code 29823 based upon reason code "X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure".

A review of the operative report indicates "...extensive debridement of all structures mentioned..." Therefore, the documentation supports billed service. As a result, reimbursement is recommended.

28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for CPT code 29823 is:

The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures. The ASC fully implemented relative payment weight for CY 2010 = 45.5859.

This number is multiplied by the 2010 Medicare ASC conversion factor of 45.5859 X \$41.873 = \$1,908.81.

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$954.40 (\$1,908.81/2).

This number X City Conversion Factor/CMS Wage Index for Austin, Texas is \$954.40 X 0.9518 = \$908.39.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement \$954.40 + \$908.39 = \$1,862.79.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment \$1,862.79 X 235% = \$4,377.55.

CPT code 29823 is subject to multiple procedure rule discounting; therefore, \$4,377.55 X 50% = \$2,188.77.

The MAR for CPT code 29823 is \$2,188.77. The insurance carrier paid \$0.00. As a result, the amount recommended for additional reimbursement is \$2,188.77.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$2186.75.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2186.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	2/21/2013 _____ Date
--------------------	---	----------------------------

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.